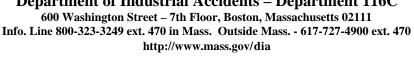
## **FORM 116C**

## The Commonwealth of Massachusetts

## **Department of Industrial Accidents – Department 116C**



DIA Board # (If Known):

## LIEN DISCLOSURE FORM TO BE COMPLETED BY THE EMPLOYEE

I,		
	(Print Name)	
hereby certify that	t, to the best of my knowledge, there are	e no outstanding
liens or claims for	reimbursement out of the proceeds of r	ny workers'
compensation sett	lement by the Department of Transition	al Assistance,
Department of Re	venue Child Support Enforcement Unit,	, Veterans
Services, prior cou	unsel, or any medical, dental, hospital o	r disability
income provider.	My workers' compensation DIA Board	number(s)
is (are):	<u>-</u>	
SIGNED UND	ER THE PAINS AND PENALTIES OF A Signature of Employee	PERJUKY.
	Address of Employee	
	Social Security Number*	
	Date	

<sup>\*</sup>Disclosure of Social Security Number is voluntary. It will assist in the processing of this document.